A closer look: Documentation and coding for behavioral health disorders

In this month’s issue of Blue Review, we are taking a closer look at behavioral health disorders. Behavioral health disorders are categorized by intense alterations in thinking, mood and/or behavior over time and can be difficult to diagnose as they are often accompanied by multiple and similar symptoms. While the Diagnostic and Statistical Manual of Mental Disorders (DSM-5®) is used to assess and diagnose the patient, the ICD-9-CM coding system is required for reimbursement.

Providers should prepare for the implementation of ICD-10 for accurate coding. These changes will certainly impact clinicians when coding and submitting claims for behavioral health conditions. It is also critical for coding staff to understand mental illness terms as many terms are closely related. If there is ambiguity in the meaning of a term or title description, best practice is to query the provider for clarification.

General documentation tips

To obtain an accurate and complete picture of a patient’s health status, clinical documentation should include:

- Reason for encounter and medical history
- Prior diagnostic test results
- Assessment, clinical impression and diagnosis
- Plan for care
- Date, name and credentials of clinician
- Reason for diagnostic and ancillary services
- Health risk factors (e.g., alcohol and drug use, diet, sleep patterns)

Schizophrenic disorders

Schizophrenic disorders are characterized by disturbances in thought, mood, sense of self; bizarre, purposeless behavior, repetitious activity or inactivity. Clinical documentation should include the type and clinical status of the disorder which is required for selection of the appropriate diagnosis code. ICD-9 requires a fourth-digit to identify the type of schizophrenic disorder and a fifth-digit to specify the clinical status. The clinical status is noted as Subchronic, Chronic, Subchronic with Acute Exacerbation, Chronic with Acute Exacerbation and in Remission.

295 Schizophrenic disorders

295.0x Simple Type
295.1x Disorganized Type
295.2x Catatonic Type
295.3x Paranoid Type
295.4x Schizophreniform Disorder
295.5x Latent Schizophrenia
295.6x Residual Type
295.7x Schizoaffective Disorder
295.8x Schizophrenia other specified types
295.9x Unspecified Schizophrenia

In ICD-10, schizophrenia has two categories: F20 schizophrenic disorders and F21 schizotypal disorders. Schizotypal disorders are personality disorders in which a person has trouble with relationships and disturbances in thought patterns, appearance and behavior. The F20 category requires a fourth-digit to identify the schizophrenia type.

Sub-category F20.8, other schizophrenia, requires a fifth digit to further define the condition. Code F20.81, schizophreniform disorder, is borderline schizophrenia disorder, not present for the full time required to diagnose schizophrenia; code F20.89, other schizophrenia, classifies all other schizophrenia types not identified by a fourth digit, for example, cenesthopathic schizophrenia or simple schizophrenia.

F20.0 Paranoid Schizophrenia
F20.1 Disorganized Schizophrenia
F20.2 Catatonic Schizophrenia
F20.3 Undifferentiated Schizophrenia
F20.5 Residual Schizophrenia
F20.8x Other Schizophrenia (requires a fifth digit)
F20.9 Unspecified Schizophrenia

Episodic mood disorders
Bipolar Disorders and Major Depressive Disorder (MDD) are episodic mood disorders. Episodic mood disorders are conditions categorized by periods of depression, sometimes alternating with periods of elevated mood. Bipolar disorder includes mania and depression while major depressive disorder is a stand-alone diagnosis. A required fourth-digit in ICD-9 identifies the episodic mood disorder type and the episode.

296.0x Bipolar Disorder, single manic episode
296.1x Manic Disorder, recurrent episode (bipolar disorder)
296.2x Major Depressive Disorder, single episode
296.3x Major Depressive Disorder, recurrent episode
296.5x Bipolar I Disorder, most recent episode (or current) manic
296.6x Bipolar I Disorder, most recent episode (or current) depressed
296.7x Bipolar I Disorder, most recent episode (or current) unspecified

The fifth-digit classification identifies the severity or the clinical status. If the episode is recent or current, the severity is noted; otherwise, the fifth digit indicates the current clinical status.

0 Unspecified
1 Mild
2 Moderate
3 Severe without psychotic behavior
4 Severe with psychotic behavior
5 In partial remission or unspecified remission
6 Full Remission
Documentation for depression requires a specific level of detail because there are two types: situational and chemical. Situational depression manifests due to life circumstances that impact the individual such as a traumatic event or death in the family. Chemical depression is caused by chemical abnormalities in the brain and is treated mainly with drugs. Based on the medical record documentation, situational depression codes to ICD-9 code 311 and major depressive disorder codes to either 296.2x or 296.3x.

However, in ICD-10 there is no distinction between depression not otherwise specified (NOS) and major depressive disorder, both descriptive titles fall under one ICD-10 code, F32.9. ICD-10 has six categories for episodic mood disorders:
- F30 Manic Episode
- F31 Bipolar Disorder
- F32 Major Depressive Disorder, Single Episode
- F33 Major Depressive Disorder, Recurrent
- F34 Persistent mood (affective) disorders
- F39 Unspecified mood (affective) disorder

The fourth-digit in ICD-10 further specifies symptoms associated with the current episode. The fifth-digit identifies the severity or the clinical status.

**Delusion disorders**
Delusional disorders are characterized by the presence of non-bizarre delusions which may persist for at least one month. In ICD-9, the required fourth-digit identifies the type of delusional disorder and there is no fifth digit assignment.
- 297.0 Paranoid State, simple
- 297.1 Delusional Disorder
- 297.2 Paraphrenia
- 297.3 Shared Psychotic Disorder
- 297.8 Other Specified Paranoid States
- 297.9 Unspecified Paranoid State

In ICD-10, delusional disorders are under one category, F22, and there is no fourth or fifth digit assignment. Shared psychotic disorder does not fall under the delusional disorder category; rather it has its own category, F24.

For more information about the transition to ICD-10, visit the Standards and Requirements section of the Blue Cross and Blue Shield of Texas (BCBSTX) provider website, bcbstx.com/provider.

**References**
1 International Classification of Diseases, 9th edition, Clinical Modification  
3 Diagnostic and Statistical Manual of Mental Disorders, 4th edition.  

*DSM and DSM-5 are registered trademarks of the American Psychiatric Association.*

*Note: This material is provided for informational purposes only and is not an endorsement of any particular site or resource. The owners/operators of each website are solely responsible for the content on their respective websites.*
Medicare crossover claims submission reminder

Blue Cross and Blue Shield Plans have been using the Centers for Medicare and Medicaid Services (CMS) crossover process to receive Medicare primary claims since January 2006. The CMS crossover process routes Medicare Supplemental claims (Medigap and Medicare Supplemental) directly from Medicare to Blue Cross and Blue Shield of Texas (BCBSTX) so that providers do not need to also submit their claim to BCBSTX.

Over the years, this Medicare crossover process has helped increase efficiency by requiring one claim submission, reducing duplicate submissions, improving payment accuracy, and increasing member and provider satisfaction.

Although the above process is clear, providers have continued to submit the claim to both Medicare and BCBSTX resulting in duplicate claims. These duplicate claims result in additional, unnecessary work and possible inaccurate claims processing, which in turn has a negative impact on providers, members, and Plans.

When the Home Plan receives a Medicare Primary claim before it is crossed over, it may be incorrectly paid based on an estimated Explanation of Medicare Benefits (EOMB). Payment should be calculated based on the actual EOMB. Members are also impacted when providers submit duplicate claims. When the Home Plan uses an estimated EOMB, they may incorrectly calculate member cost sharing.

In an effort to improve the Medicare crossover administrative process, all providers are instructed to follow new rules concerning Medicare secondary claim submission. CMS requires that when a Medicare claim has been crossed over, providers are to wait 30 calendar days from the initial Medicare remittance date before submitting the claim to BCBSTX.

BCBSTX will reject provider submitted claims when Medicare is considered primary including those with Medicare exhausted-benefits that have crossed over if they are received within 30 calendar days of the initial remittance date or with no Medicare remittance date. It is expected that this modification will address duplicate claim submissions.

How do I submit a claim when Medicare is primary and Blue Plan is secondary?

- Submit claims to your Medicare carrier when Medicare is considered primary and the Blue Plan is secondary.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member’s ID card for additional verification.
- Be sure to include the alpha prefix as part of the member number. This alpha prefix is located on the member’s ID card as the first three characters. The alpha prefix is critical for confirming membership and coverage, and if not provided, may delay payments.

When you receive the remittance advice from Medicare, determine if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- Remark codes MA18 or N89 on the Medicare remittance will indicate that the claim was crossed over. The claim has been sent on your behalf to the appropriate Blue Plan for processing. You do not need to resubmit that claim to BCBSTX.
• If the remittance indicates that the claim was not crossed over, submit the claim to BCBSTX with the Medicare remittance advice.
• In some cases, the member ID card may include a Coordination of Benefits Agreement ID number. If so, be certain to include that number on your claim.

If you have any questions or need to request the status of a claim, inquiries should be submitted in the following manner:
• Electronically – send a HIPAA transaction 276 (claim status inquiry) to BCBSTX through your preferred online vendor portal.
• Call our Provider Customer Service at 800-451-0287.

When should I expect to receive payment?
The claims you submit to the Medicare carrier will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately 14 business days to occur. This means that Medicare will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional business days for you to receive payment or instructions from the Blue Plan.

What should I do in the meantime?
If you submitted the claim to the Medicare carrier, and haven’t received a response to your initial claim submission, do not automatically submit another claim. Rather, you should:
• Review the automated resubmission cycle on your claim system.
• Wait 30 calendar days from receipt of the Medicare Remittance advice.
• To avoid submitting a duplicate claim, check the status of the initial claim before resubmitting.

If you use a billing service or clearinghouse to submit claims on your behalf, please be sure they are aware of this information. For more information about submitting claims or checking the status of a claim, visit the Claims and Eligibility section of the BCBSTX provider website, bcbstx.com/provider.

BlueCompareSM for physicians
Blue Cross and Blue Shield of Texas (BCBSTX) evaluates the performance of Blue Choice PPOSM network physicians in 13 measured specialties on Evidence Based Measures (EBM) and Physician Cost Assessment (PCA) as compared to peers in the same working specialty.

Consistent with national guidelines, a cost-efficiency assessment is only performed if the specialty-specific, quality-related criteria are met. This years’ evaluation is underway, and we will mail the affected physicians a communication with instructions for accessing their performance reports in a secure online portal (if applicable).

BCBSTX also has two additional transparency programs that provide quality-related performance information on the National Doctor & Hospital FinderSM and the BCBSTX Provider Finder.
The Physician Quality Measurement Program (PQM) collects data on nationally endorsed physician quality measures, Evidence Based Measures. Physician's practices PQM results shown on the physician's BlueCompare 2014 EBM Summary Report will be displayed on the National Doctor & Hospital Finder effective third quarter of 2014.

The Blue Physician Recognition (BPR) will use a BPR indicator to identify physicians who have demonstrated their commitment to delivering quality and patient-centered care, as determined by BCBSTX. If a physician receives a Blue Ribbon for the BCBSTX 2014 BlueCompare program, the BPR symbol will be displayed on the National Doctor & Hospital Finder and the BCBSTX Provider Finder effective third quarter of 2014. Similar information will be displayed for PQM in the future on the BCBSTX Provider Finder.

If you have any questions, we invite you to visit the BCBSTX provider website at bcbstx.com for more detailed information. Go to the Provider Training page at http://www.bcbstx.com/provider/training/index.html and click on Blue Compare for Physicians. If you would like to speak to someone, please call your Provider Relations representative.

NOTICES AND ANNOUNCEMENTS

Performance measurement codes
Effective July 1, 2014, Blue Cross and Blue Shield of Texas (BCBSTX) will begin reimbursing additional Category II CPT® codes. The complete list is outlined below.

<table>
<thead>
<tr>
<th>Category II Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0500F</td>
<td>Initial prenatal care visit (report as first prenatal encounter with health care professional providing obstetrical care)</td>
</tr>
<tr>
<td>0501F</td>
<td>Prenatal flow sheet documented in medical record by first prenatal visit</td>
</tr>
<tr>
<td>0503F</td>
<td>Postpartum care visit</td>
</tr>
<tr>
<td>0518F</td>
<td>Falls plan of care documented</td>
</tr>
<tr>
<td>1003F</td>
<td>Level of activity assessed</td>
</tr>
<tr>
<td>1022F</td>
<td>Pneumococcus immunization status assessed</td>
</tr>
<tr>
<td>1030F</td>
<td>Influenza immunization status assessed</td>
</tr>
<tr>
<td>1034F</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td>1035F</td>
<td>Current smokeless tobacco user</td>
</tr>
<tr>
<td>1100F</td>
<td>Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year</td>
</tr>
<tr>
<td>Category II Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1111F</td>
<td>Discharge medications reconciled with the current medication list in outpatient medical record</td>
</tr>
<tr>
<td>1123F</td>
<td>Advance care planning discussed &amp; documented; advance care plan or surrogate decision maker documented in the medical record</td>
</tr>
<tr>
<td>1124F</td>
<td>Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide and advance care plan</td>
</tr>
<tr>
<td>1157F</td>
<td>Advance care plan or similar legal document present in the medical record</td>
</tr>
<tr>
<td>1158F</td>
<td>Advance care planning discussion documented in the medical record</td>
</tr>
<tr>
<td>3011F</td>
<td>Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)</td>
</tr>
<tr>
<td>3014F</td>
<td>Screening mammography results documented and reviewed</td>
</tr>
<tr>
<td>3015F</td>
<td>Cervical cancer screening results documented and reviewed</td>
</tr>
<tr>
<td>3017F</td>
<td>Colorectal cancer screening results documented and reviewed</td>
</tr>
<tr>
<td>3023F</td>
<td>Spirometry results documented and reviewed</td>
</tr>
<tr>
<td>3025F</td>
<td>Spirometry test results demonstrate FEV1/FVC less than 70% with COPD symptoms</td>
</tr>
<tr>
<td>3027F</td>
<td>Spirometry test results demonstrate FEV1/FVC greater than or equal to 70% or patient does not have COPD symptoms</td>
</tr>
<tr>
<td>3044F</td>
<td>Most recent hemoglobin A1C level &lt; 7.0%</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent hemoglobin A1C level 7.0% to 9.0%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent hemoglobin A1C level &gt; 9.0%</td>
</tr>
<tr>
<td>3048F</td>
<td>Most recent LDL-C &lt; 100mg/dL</td>
</tr>
<tr>
<td>3049F</td>
<td>Most recent LDL-C 100-129mg/dL</td>
</tr>
<tr>
<td>3050F</td>
<td>Most recent LDL-C ≥130mg/dL</td>
</tr>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3061F</td>
<td>Negative microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3062F</td>
<td>Positive macroalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3210F</td>
<td>Group A strep test performed</td>
</tr>
<tr>
<td>Category II Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>3288F</td>
<td>Falls risk assessment documented</td>
</tr>
<tr>
<td>3330F</td>
<td>Imaging study ordered</td>
</tr>
<tr>
<td>3331F</td>
<td>Imaging study not ordered</td>
</tr>
<tr>
<td>4000F</td>
<td>Tobacco use cessation intervention, counseling</td>
</tr>
<tr>
<td>4001F</td>
<td>Tobacco use cessation intervention, pharmacologic therapy</td>
</tr>
<tr>
<td>4002F</td>
<td>Statin therapy prescribed</td>
</tr>
<tr>
<td>4004F</td>
<td>Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user</td>
</tr>
<tr>
<td>4008F</td>
<td>Beta-blocker prescribed or currently being taken</td>
</tr>
<tr>
<td>4025F</td>
<td>Inhaled bronchodilator prescribed</td>
</tr>
<tr>
<td>4035F</td>
<td>Influenza immunization recommended</td>
</tr>
<tr>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
<tr>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received</td>
</tr>
<tr>
<td>4050F</td>
<td>Hypertension plan of care documented as appropriate</td>
</tr>
<tr>
<td>4124F</td>
<td>Antibiotic neither prescribed nor dispensed</td>
</tr>
<tr>
<td>4140F</td>
<td>Inhaled corticosteroids prescribed</td>
</tr>
<tr>
<td>4144F</td>
<td>Alternative long-term control medication prescribed</td>
</tr>
<tr>
<td>4154F</td>
<td>Hepatitis A vaccine series recommended</td>
</tr>
</tbody>
</table>

These codes facilitate data collection about quality of care. They allow physicians to report services based on nationally established, evidence based performance guidelines for improving quality of patient care. The codes will provide us with information unavailable from claims data. We encourage physicians to report these codes. Reimbursement of these codes supports the BCBSTX goal of improving the health of the population and our focus on wellness.

**NOTE:** When billing Category II Codes, submit your usual charge. Please do not submit the codes with a $0 charge.
Fee schedule update
BCBSTX will implement changes in the maximum allowable fee schedule used for Blue Choice PPO\textsuperscript{SM}, HMO Blue Texas\textsuperscript{SM}, Blue Advantage HMC\textsuperscript{SM} (Independent Provider Network and THE Limited Network only), and ParPlan effective July 1, 2014.

- The methodology used to develop the maximum allowable fee schedule for Blue Choice PPO and HMO Blue Texas will be based on 2014 CMS values posted on the CMS website as of January 31, 2014 for those services for which the BCBSTX reimbursement is based on CMS values.

- The methodology used to develop the maximum allowable fee schedule for Blue Advantage HMO will be based on BCBSTX weights posted on the website.

- Geographic Practice Cost Indices (GPCIs) will not be applied to the relative values so the relative values will not differ by Medicare locality.

- HMO Blue Texas, Blue Choice PPO, and ParPlan relative values and Blue Advantage HMO weights will consider the site of service where the service is performed (facility or non-facility).

- Effective June 1, 2014, BCBSTX will revise the methodology utilized for determining the allowables for CPT and HCPCS codes associated with multiple National Drug Codes (NDCs), including immunizations. The HCPCS or CPT code allowable generally will be equivalent to the lowest NDC allowable associated with the HCPCS or CPT code.

- The CPT/HCPCS Fee Schedule will be updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year.

- The NDC Fee Schedule will be updated monthly.

- Effective July 1, 2014, if Physical Status Modifiers P3, P4 or P5 are billed, the full unit value for these Physical Status Modifiers will be reimbursed even if the obstetrical delivery total maximum allowable points have been met.

BCBSTX provides general reimbursement information policies, request forms for allowable fees and fee schedule information at bcbstx.com/provider. To view this information, visit the General Reimbursement Information section on the website. If you would like to request a sample of maximum allowable fees or if you have any other questions, please contact your Provider Relations office.

Reimbursement changes will be posted under Reimbursement Changes/Updates in the Professional Reimbursement Schedules section on the BCBSTX provider website. The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted.

Enhancements in claims processing efficiency
In the April and July 2013 issues of Blue Review, we informed you that BCBSTX will begin accepting partial batches, rejecting only individual claims that do not meet HIPAA compliance standards. These enhancements will be effective in April 2014.
When you transmit ANSI 5010 837 professional or institutional claim file(s), BCBSTX will forward all valid and successful claims for processing and adjudication. Our payer response reports will indicate which claims were rejected so that those claims may be corrected and resubmitted as appropriate. The entire batch of claims should not be resubmitted, as this will result in duplicate claims within the adjudication process.

If you use a billing service or clearinghouse to submit claims on your behalf, please be sure they are aware of this information.

If you have any questions about this notice, please contact our Electronic Commerce Center at 800-746-4614 for further assistance.

Introducing new quarterly highlights for pharmacy news
BCBSTX would like to introduce a new feature on our provider website. For your review, each quarter, we will provide a brief summary of the new pharmacy products and program enhancements that were announced in Blue Review during the previous quarter along with a link to the article.

The listing of pharmacy topics covered in the first quarter of 2014 includes:

- Self-administered specialty drug claim processing reminder
- Checking your records for outdated drug codes
- Fourth quarter 2013 GuidedHealth® program updates
- Pharmacy program updates
- Electronic options for prescription drug prior authorization requests

Watch for the new Pharmacy Optimization Initiative 1st Quarter 2014 Highlights link on the homepage of the BCBSTX provider website at bcbtx.com/provider.

GuidedHealth is a registered trademark of Prime Therapeutics LLC (Prime), a pharmacy benefit management company. Blue Cross and Blue Shield of Texas (BCBSTX) contracts with Prime to provide pharmacy benefit management, prescription home delivery and specialty pharmacy services. BCBSTX, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime. BCBSTX makes no endorsement, representations or warranties regarding GuidedHealth. If you have any questions about this product or services, you should contact Prime Therapeutics LLC directly.

Networks offered on the Texas Health Insurance Marketplace
Open enrollment for the new Health Insurance Marketplace began Oct. 1, 2013. BCBSTX is offering two networks on the Texas Health Insurance Marketplace effective Jan. 1, 2014 for all enrollees:

- Blue Advantage HMO℠
- Blue Choice PPO℠
Both networks are available in all 254 Texas counties and will be offered on and off the Texas Health Insurance Marketplace. Product names currently offered on the Texas Health Insurance Marketplace are listed below.

<table>
<thead>
<tr>
<th>PPO</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Choice Gold PPO 001</td>
<td>Blue Advantage Gold HMO 001</td>
</tr>
<tr>
<td>Blue Choice Gold PPO 002</td>
<td>Blue Advantage Gold HMO 002</td>
</tr>
<tr>
<td>Blue Choice Silver PPO 003</td>
<td>Blue Advantage Silver HMO 003</td>
</tr>
<tr>
<td>Blue Choice Silver PPO 004</td>
<td>Blue Advantage Silver HMO 004</td>
</tr>
<tr>
<td>Blue Choice Bronze PPO 005</td>
<td>Blue Advantage Bronze HMO 005</td>
</tr>
<tr>
<td>Blue Choice Bronze PPO 006</td>
<td>Blue Advantage Bronze HMO 006</td>
</tr>
<tr>
<td>Blue Security Choice PPO 010</td>
<td></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Premier 1, a Multi-State Plan (PPO)</td>
<td></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Premier 2, a Multi-State Plan (PPO)</td>
<td></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Solution 3, a Multi-State Plan (PPO)</td>
<td></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Solution 4, a Multi-State Plan (PPO)</td>
<td></td>
</tr>
<tr>
<td>Blue Cross Blue Shield Basic 5, a Multi-State Plan (PPO)</td>
<td></td>
</tr>
</tbody>
</table>

If you have questions, please contact the BCBSTX Provider Relations department.

**Billing with National Drug Codes**

BCBSTX reimburses claims submitted with National Drug Code (NDC) in accordance with the NDC Fee Schedule posted on the BCBSTX provider website, [bcbstx.com/provider](http://bcbstx.com/provider), under Drugs. To locate this information, click the Standards & Requirements tab, then select General Reimbursement Information, enter password, then scroll down to the Reimbursement Schedules and Related Information area, then go to Professional and select the Blue Choice PPO and HMO Blue Texas Schedules offering, then select 2014 Schedules effective July 1, 2014, then scroll down to Drugs. The NDC Fee Schedule is updated monthly on the first of each month.

Lower-cost generic medications may be reimbursed with a larger margin compared to higher-cost generic and brand medications. In addition, effective June 1, 2014, BCBSTX will revise the methodology utilized for determining the allowables for Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes associated with multiple NDCs, including immunizations. The HCPCS or CPT code allowable generally will be equivalent to the lowest NDC allowable associated with the HCPCS or CPT code.

When drugs are billed under the medical benefit on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims, it is important to include NDCs and related data. Using NDCs on medical claims facilitates more accurate payment and better management of drug costs based on what was dispensed. Physicians and ancillary providers are encouraged to include NDC information on claims.
BCBSTX requires inclusion of the NDC along with the applicable HCPCS or CPT code(s) on claim submissions for unlisted or "Not Otherwise Classified" (NOC) physician or ancillary provider administered and supplied drugs. BCBSTX will continue to accept the HCPCS or CPT code elements without NDC information (excluding unlisted or "Not Otherwise Classified" drugs).

As a reminder, when submitting NDCs on professional/ancillary electronic (ANSI 837P) and paper (CMS-1500) claims to BCBSTX, you must also include the following related information:

- The applicable HCPCS or CPT code
- Number of HCPCS/CPT units
- NDC qualifier (N4)
- NDC unit of measure (UN – Unit, ML – Milliliter, GR – Gram, F2 – International Unit)
- Number of NDC units (up to three decimal places)
- Your billable charge/price per unit

**Attention electronic claim submitters:** If you have converted to ANSI 5010, there should be no additional software requirements when NDCs are included on electronic claims. However, please verify with your software vendor to confirm that your Practice Management System accepts and transmits the NDC data fields appropriately. If you use a billing service or clearinghouse to submit electronic claims on your behalf, please check with them to ensure that NDC data is not manipulated or dropped inadvertently.

For additional information to assist you with using NDCs on medical claims, please refer to the **Billing with National Drug Codes (NDC)** information in the Claims and Eligibility/Submitting Claims section of our website at bcbstx.com/provider. You will also find other NDC-related resources on our website, such as answers to Frequently Asked Questions, an interactive online tutorial and the NDC Units Calculator Tool.

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**IN EVERY ISSUE**

**After-hours access is required**
Blue Cross and Blue Shield of Texas (BCBSTX) requires that primary care physicians and specialty care physicians and professional providers provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. They must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

**Acceptable after-hours access mechanisms may include:**

- An answering service that offers to call or page the physician or on-call physician;

Blue Review, April 2014
A recorded message that directs the patient to call the answering service and the phone number is provided; or
A recorded message that directs the patient to call or page the physician or on-call physician and the phone number is provided.

For more detail, please refer to the provider manuals for Blue Choice PPO℠ Physician and Professional Provider (Section B) and HMO Blue Texas℠ Physician and Professional Provider (Section B) available on our provider website at bcbstx.com/provider. Click on the "Education & Reference" tab, then click on "Manuals" and enter the password.

BCBS Medicare Advantage PPO network sharing

What is Blue Cross and Blue Shield (BCBS) Medicare Advantage (MA) PPO network sharing?
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO network sharing mean to me?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX) and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with BCBSTX and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?
You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

The “MA” in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.
Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

If you are a contracted BCBS MA PPO provider with BCBSTX, you should provide the same access to care for BCBS MA members from other BCBS Plans as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard Eligibility at 800-676-BLUE (800-676-2583) and provide the BCBS MA PPO member’s alpha prefix located on the member’s ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to the Availity Portal, the Availity Revenue Cycle Management Portal or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?

You should submit the claim to BCBSTX under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?

If you are a BCBS MA PPO contracted provider with BCBSTX, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?

When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, BCBSTX will send you the payment. However, these services will be paid under the BCBS MA member’s out-of-network benefits unless for urgent or emergency care.
What is the BCBS MA PPO member cost sharing level and co-payments?
A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member's health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (800-676-2583).

May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?
No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact Blue Cross Medicare Advantage (PPO)SM Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 877-774-8592.

Medical record requests: Include our letter as your cover sheet
When you receive a letter from BCBSTX requesting additional information such as medical records or certificates of medical necessity, please utilize the letter as a cover sheet when sending the requested information to us.

This letter contains a barcode in the upper right corner of the page to help ensure that the information you send is matched directly to the appropriate file and/or claim. Do not submit a Claim Review Form in addition to the letter, as this could delay the review process.

Thank you for your cooperation!

Technical and professional components
Modifiers 26 and TC: Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes technical component for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only.

Note: When a physician or professional provider performs both the technical and professional service for a lab or radiological procedure, he/she must submit the total service, not each service individually.

Surgical procedures performed in the physician's office
When performing surgical procedures in a non-facility setting, the physician and professional provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or professional provider's office.
Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3.

Please note the physician and professional provider’s reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff and equipment.

AIM RQI/Preauthorization reminder
Physicians and professional providers must contact AIM Specialty Health® (AIM), first to obtain a Radiology Quality Initiative (RQI) for Blue Choice PPO members and Blue Advantage HMO members or a Preauthorization for HMO Blue Texas members when ordering or scheduling the following outpatient, non-emergency diagnostic imaging services when performed in a physician's office, a professional provider’s office, the outpatient department of a hospital or a freestanding imaging center:
- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

To obtain a Blue Choice PPO/Blue Advantage HMO RQI or an HMO Blue Texas Preauthorization, log in to AIM’s provider portal at aimspecialtyhealth.com and complete the online questionnaire that identifies the reasons for requesting the exam. If criteria are met, you will receive a RQI or Preauthorization (whichever is applicable). If criteria are not met or if additional information is needed, the case will automatically be transferred for further clinical evaluation and an AIM nurse will follow up with your office. AIM’s ProviderPortalSM uses the term “Order” rather than “Preauth” or “RQI.”

Note: Facilities cannot obtain an RQI or a Preauthorization from AIM on behalf of the ordering physician. Also, the RQI or Preauthorization program does not apply to Medicare enrollees with BCBSTX Medicare supplement coverage. Medicare enrollees with BCBSTX commercial PPO or HMO coverage are included in the program.

AIM Specialty Health (AIM) is an operating subsidiary of WellPoint, Inc.

Quest Diagnostics, Inc., is the exclusive HMO and preferred statewide PPO clinical reference lab provider
Quest Diagnostics, Inc., is the exclusive outpatient clinical reference laboratory provider for HMO Blue TexasSM and Blue Advantage HMO² members* and the preferred statewide outpatient clinical reference laboratory provider for BCBSTX Blue Choice PPO² members. This arrangement excludes lab services provided during emergency
room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

**Quest Diagnostics Offers:**
- On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a patient PSC appointment, log onto [QuestDiagnostics.com/patient](http://www.QUESTDiagnostics.com/patient) or call 888-277-8772.
- Convenient patient access to more than 195 patient service locations.
- 24/7 access to electronic lab orders, results, and other office solutions through Care360® Labs and Meds.

For more information about Quest Diagnostics lab testing solutions or to establish an account, contact your Quest Diagnostics Physician Representative or call 866-MY-QUEST (866-697-8378).

For physicians and professional providers located in the HMO capitated lab counties, only the lab services/tests indicated on the Reimbursable Lab Services list will be reimbursed on a fee-for-service basis if performed in the physician’s or professional provider’s office for HMO Blue Texas members. Please note all other lab services/tests performed in the physician’s or professional provider’s office will not be reimbursed. You can access the county listing and the Reimbursable Lab Services list at [bcbstx.com/provider](http://www.bcbstx.com/provider) under the General Reimbursement Information section located under the Standards and Requirements tab.

*Note*: Physicians & professional providers who are contracted/affiliated with a capitated IPA/medical group and physicians & professional providers who are not part of a capitated IPA/medical group but who provide services to a member whose PCP is a member of a capitated IPA/medical group must contact the applicable IPA/medical group for instructions regarding outpatient laboratory services.

**Fee schedule updates**
Reimbursement changes and updates for Blue Choice PPO and HMO Blue Texas (Independent Provider Network only) and Blue Advantage HMO practitioners will be posted under Standards and Requirements / General Reimbursement Information / Reimbursement Schedules and Related Information / Professional Schedules section on the BCBSTX provider website at [bcbstx.com/provider](http://www.bcbstx.com/provider).

The changes will not become effective until at least 90 days from the posting date. The specific effective date will be noted for each change that is posted. To view this information, visit the General Reimbursement Information section on the BCBSTX provider website. Also, the Drug/Injectable Fee Schedule will be updated on June 1, 2014.

**Improvements to the medical records process for BlueCard® claims**
BCBSTX is now able to send medical records electronically to all Blue Cross and/or Blue Shield Plans. This method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims and eliminates lost or misrouted records.
As always, we will request that you submit your medical records to BCBSTX if needed for claims processing.

Requests for medical records from other Blues Plans before rendering services, as part of the preauthorization process, should be submitted directly to the requesting Plan.

**Pass-through billing**

BCBSTX does not permit pass-through billing. Pass-through billing occurs when the ordering physician or professional provider requests and bills for a service, but the service is not performed by the ordering physician or professional provider.

The performing physician or professional provider should bill for these services unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing physician or professional provider is performed at the place of service of the ordering provider and is billed by the ordering physician or professional provider.

- The service is provided by an employee of a physician or professional provider (physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider) and the service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA):

- **AS modifier**: A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned providers are acting as an assistant during surgery. (Modifier AS is to be used ONLY if they assist at surgery.)

- **SA modifier**: A supervising physician should use this modifier when billing on behalf of a PA, APN or CRNFA for non-surgical services. (Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that DOES NOT include surgery.)

**Contracted physicians and professional providers must file claims**

As a reminder, physicians and professional providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your physician and professional provider contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full
and directs a physician or professional provider to not file a claim with the patient’s insurer, the physician or professional provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

**Medical policy disclosure**

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted.

To view active and pending medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to active and pending medical policies.

**Draft medical policy review**

In an effort to streamline the medical policy review process, you can view draft medical policies on the BCBSTX provider website and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

To view draft medical policies go to [bcbstx.com/provider](http://bcbstx.com/provider) and click on the Standards & Requirements tab, then click on the Medical Policies offering. After reading and agreeing to the disclaimer, you will then have access to view any draft medical policies, if available.

**No additional medical records needed**

Physicians and professional providers who have received an approved predetermination (which establishes medical necessity of a service) or have obtained a radiology quality initiative (RQI) from AIM Specialty Health need not submit additional medical records to BCBSTX. In the event that additional medical records are needed to process a claim on file, BCBSTX will request additional medical records at that time.

Predetermination does not guarantee payment. All payments are subject to determination of the insured person’s eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

**Importance of obtaining preauthorization for initial stay and add-on days**

Preauthorization is required for certain types of care and services. Although BCBSTX participating physicians and professional providers are required to obtain the preauthorization, it is the responsibility of the insured person to confirm that their physician or professional provider obtains preauthorization for services requiring
preauthorization. Preauthorization must be obtained for any initial stay in a facility and any additional days or services added on.

If an insured person does not obtain preauthorization for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced.

Preauthorization does not guarantee payment. All payments are subject to determination of the insured person’s eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations, and other provisions of the policy at the time services are rendered.

**Avoidance of delay in claims pending COB information**

BCBSTX receives thousands of claims each month that require unnecessary review for coordination of benefits (COB). What that means to our physicians and professional providers is a possible delay, or even denial of services, pending receipt of the required information from the member.

Here are some tips to help prevent claims processing delays when there is only one insurance carrier:

- CMS-1500, box 11-d – if there is no secondary insurance carrier, mark the “No” box.
- Do not place anything in box 9, a through d – this area is reserved for member information for a secondary insurance payer.

It is critical that no information appears in box 11-d or in box 9 a-d if there is only one insurance payer.

**Billing for non-covered services**

As a reminder, contracted physicians and professional providers may collect payment from subscribers for copayments, co-insurance and deductible amounts. The physician or professional provider may not charge the subscriber more than the patient share shown on their provider claim summary (PCS) or electronic remittance advice (ERA).

In the event that BCBSTX determines that a proposed service is not a covered service, the physician or professional provider must inform the subscriber in writing in advance. This will allow the physician or professional provider to bill the subscriber for the non-covered service rendered.

In no event shall a contracted physician or professional provider collect payment from the subscriber for identified hospital acquired conditions and/or serious reportable events.

**Dispensing QVT (quantity versus time) limits**

To help minimize health risks and to improve the quality of pharmaceutical care, dispensing QVT limits have been placed on select prescription medications. The limits are based upon the U.S. Federal Drug Administration and medical guidelines as well as the drug manufacturer’s package insert.
Visit the BCBSTX provider website at bcbstx.com/provider to access the 2014 Drug Dispensing Limits list.

**Preferred drug list**
Throughout the year, the BCBSTX Clinical Pharmacy Department team frequently reviews the preferred drug list. Tier placement decisions for each drug on the list follow a precise process, with several committees reviewing efficacy, safety and cost of each drug.

For the 2014 drug updates, visit the BCBSTX provider website under the Pharmacy Program tab, or follow this link: bcbstx.com/provider/pharmacy/index.html and click on the Preferred Drug Guide offering in the left-side navigation list.

**Are utilization management decisions financially influenced?**
BCBSTX is dedicated to serving our customers through the provision of health care coverage and related benefit services. BCBSTX prohibits decisions based on financial incentives – utilization management decisions are based on appropriateness of care and service and existence of coverage.

BCBSTX does not specifically reward practitioners or clinicians for issuing denials of coverage, nor is there compensation based on the number or frequency of telephone calls or other contacts that occur with health care providers or members. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

**Contact Us**
Click here for a quick directory of contacts at BCBSTX.

**Update your contact information online**
To update your contact information, go to bcbstx.com/provider, click on the Network Participation tab and follow the directions under Update Your Contact Information. This process allows you to electronically submit a change to your name, office or payee address, email address, telephone number or other information. You should submit all changes at least 30 days in advance of the effective date of the change.

If your specialty, practice information/status or board certification is not correct on the BCBSTX Provider Finder®, or if you would like to have a subspecialty added, you can enter the information in the Other field or contact your Provider Relations office.

*Blue Review* is published for Blue Choice PPO℠, HMO Blue Texas℠, Blue Cross Medicare Advantage (PPO)℠, Blue Advantage HMO℠ and ParPlan contracting physicians and other health care providers. Ideas for articles and letters to the editor are welcome; email BlueReviewEditor@bcbstx.com.
The information provided in *Blue Review* does not constitute a summary of benefits, and all benefit information should be confirmed or determined by calling the customer service telephone number listed on the back of the member ID card.

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